



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

RENAISSANCE HOSPITAL  
C/O BURTON & HYDE PLLC  
PO BOX 684749  
AUSTIN TX 78768-4749

#### **Respondent Name**

ZURICH AMERICAN INSURANCE COMPANY

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-08-3651-01

#### **MFDR Date Received**

February 11, 2008

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "...the fair and reasonable reimbursement amount for this hospital outpatient admission should be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."

**Amount in Dispute:** \$3,450.04

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that \$1,028.77 represents an amount greater than or equal to the fair and reasonable reimbursement for this service. The provider must therefore prove that the reimbursement received is not fair and reasonable. . . . Because Requestor has failed to prove that the reimbursement received is not fair and reasonable, Requestor is not entitled to further reimbursement."

**Response Submitted by:** Flahive, Ogden & Latson, Post Office Drawer 201329, Austin, TX 78720

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 25, 2007	Outpatient Services	\$3,450.04	\$3,440.21

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.

3. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.
4. U.S. Bankruptcy Judge Michael Lynn issued a “STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS,” dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers’ compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor’s estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer’s behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
5. By letter dated August 2, 2011, the attorney for the requestor provided *REQUESTOR’S AMENDED POSITION STATEMENT (RENAISSANCE HOSPITAL – GROVES)* that specified, in pertinent parts, an “Additional Reimbursement Amount Owed” of \$3,440.21 and an “alternative” “Additional Reimbursement Amount Owed” of \$2,474.93. The Division notes that the amount in dispute of \$3,450.04 specified above is the original amount in dispute as indicated in the requestor’s *TABLE OF DISPUTED SERVICES* submitted prior to the *REQUESTOR’S AMENDED POSITION STATEMENT*.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
  - 226 – INCLUDED IN GLOBAL CHARGE.
  - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
  - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

## **Findings**

1. This dispute relates to outpatient hospital services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
  - The requestor’s amended position statement asserts that “the fair and reasonable reimbursement amount for this hospital outpatient admission should at least be commensurate with the average amount paid by all insurance carriers in the Texas workers’ compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code.”
  - In support of the requested reimbursement methodology the requestor states that “Ordering additional reimbursement based on the average amount paid system-wide in Texas achieves effective medical cost control because it prevents overpayment. . . . creates an expectation of fair reimbursement; and . . . encourages health care providers to continue to offer quality medical care to injured employees . . . Ordering additional reimbursement for at least the average amount paid for a hospital outpatient admission during the same year of service and involving the same Principal Diagnosis Code and Principal Procedure Code ensures that similar procedures provided in similar circumstances receive similar reimbursement. . . . The average amount paid for similar admissions as put forward by the Requestor is based on a study of data maintained by the Division.”

- The Division notes that it has utilized similar data to determine “fair and reasonable” fee guidelines. See, for example, the adoption preamble to the *Hospital Facility Fee Guideline—Outpatient* at 28 Texas Administrative Code §134.403, 33 *Texas Register* 400-407, which specified, in pertinent parts, that “In maintaining a medical billing database, the Division requires carriers to submit billing and reimbursement information to the Division on a regular basis . . . The Division provided Milliman with the 837 data set for CY 2005, which included information on approximately 12,000 inpatient billing lines and 166,000 hospital outpatient billing lines . . . Milliman estimated that CY 2005 Texas workers' compensation outpatient facility reimbursement represented approximately 186 percent of Medicare allowable levels for outpatient services . . . The Division considered the issues of medical cost containment as prescribed by Labor Code §413.011 . . . Research conducted by the Workers' Compensation Research Institute concludes that . . . hospital outpatient payments per claim in Texas were lower than the 13-state median studied . . . Based on all of these factors . . . The Division adopts PAFs of 200 percent and 130 percent of Medicare reimbursement for use in determining Texas workers' compensation outpatient facility service reimbursement.”
- The requestor submitted documentation to support the state-wide, annual, average reimbursement in Texas for the principal diagnosis code and principal procedure code of the disputed services during the year that the services were rendered.
- The requestor has explained and supported that the requested reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is supported. Thorough review of the submitted documentation finds that the requestor has discussed, demonstrated, and justified that the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as the disputed admission for those admissions involving the same principal diagnosis code and principal procedure code is a fair and reasonable rate of reimbursement for the services in dispute.

4. In the alternative, the requestor proposes that “it is justifiable to order additional reimbursement under the Hospital Facility Fee Guidelines – Outpatient because the Division’s new fee guidelines, while not in effect at the time, are presumptively fair and reasonable reimbursement under the law and data from the Medicare Outpatient Prospective Payment System for this date of service is available for calculating the amount due.” Review of the submitted documentation finds that:
  - In support of this alternative reimbursement methodology the requestor states that “The data necessary to calculate the Maximum Allowable Reimbursement for this year of service is readily available from the Medicare Outpatient Prospective Payment System. Therefore, the new fee guidelines as adopted in 28 TEX. ADMIN. CODE § 134.403 provide a presumptive measure of the fair and reasonable reimbursement amount.”
  - The requestor did not submit documentation to support the Medicare payment calculation for the services in dispute.
  - The fee guidelines as adopted in 28 Texas Administrative Code §134.403 were not in effect during the time period when the disputed services were rendered.
  - The Division disagrees that the fee guidelines as set forth in §134.403 are “presumptively fair and reasonable reimbursement under the law” for dates of service prior to the date the rule became effective. No documentation was found to support such a presumption under law.
  - While the Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients (22 *Texas Register* 6284), Texas Labor Code §413.011(b) requires that “In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d)... This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services.”
  - The requestor did not discuss or present documentation to support how applying the proposed payment adjustment factors as adopted in 28 Texas Administrative Code §134.403, effective for dates of service on or after March 1st, 2008, would provide fair and reasonable reimbursement for the disputed services during the time period that treatment was rendered to the injured worker.
  - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the alternative requested reimbursement.
  - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for the alternative additional amount of \$2,474.93 is not supported. The requestor has not demonstrated or presented sufficient documentation to support that the alternative additional amount requested would provide a fair and reasonable rate of reimbursement for the services in dispute.

5. 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(V), effective December 31, 2006, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, requires the respondent to provide “documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 of this title if the dispute involves health care for which the Division has not established a MAR, as applicable.” Review of the submitted documentation finds that:
- The respondent has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
  - The respondent’s position statement asserts that “The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that \$1,028.77 represents an amount greater than or equal to the fair and reasonable reimbursement for this service.”
  - The respondent did not explain the methodology used to calculate the reimbursement amount for the services in dispute.
  - The respondent did not submit documentation to support the reimbursement calculations.
  - The respondent did not submit information to support that the reimbursement methodology used to calculate the payment provides for a fair and reasonable reimbursement for the services in dispute.
  - The respondent did not discuss or explain how the amount paid represents a fair and reasonable reimbursement for the services in dispute.
  - The respondent did not submit documentation to support that the amount paid is a fair and reasonable rate of reimbursement for the disputed services.
  - The respondent did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support that the amount paid is a fair and reasonable reimbursement for the services in dispute.
  - The respondent did not explain how the amount paid satisfies the requirements of 28 Texas Administrative Code §134.1.

The respondent’s position is not supported. Thorough review of the submitted documentation finds that the respondent has not demonstrated or justified that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute. The Division concludes that the respondent has not met the requirements of 28 Texas Administrative Code §133.307(d)(2)(A)(iv)(V).

6. The Division finds that the documentation submitted in support of the fair and reasonable methodology proposed by the requestor based on the average amount paid by all insurance carriers in the same year for admissions involving the same principal diagnosis code and principal procedure code as the services in dispute is the best evidence in this dispute of an amount that will achieve a fair and reasonable reimbursement for the services in this dispute. Reimbursement will therefore be calculated as follows. Review of the medical bill finds that the principal diagnosis code for the disputed services is 717.7. The principal procedure code is 77.66. The requestor submitted documentation to support that the average, state-wide reimbursement for this diagnosis code and procedure code performed in 2007 was \$4,468.98. This amount less the amount previously paid by the respondent of \$1,028.77 leaves an amount due to the requestor of \$3,440.21. This amount is recommended.

## **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the requestor has established that additional reimbursement is due. The Division concludes that the carrier’s response was not submitted in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the respondent failed to support that the amount paid by the insurance carrier is a fair and reasonable reimbursement in accordance with Division rule at 28 Texas Administrative Code §134.1. As a result, the amount ordered is \$3,440.21.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$3,440.21 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

### **Authorized Signature**

<hr/>	<hr/> <b>Grayson Richardson</b> <hr/>	<hr/> <b>February 4, 2013</b> <hr/>
Signature	Medical Fee Dispute Resolution Officer	Date

## ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**